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# The Continuous Treatment Rule: Ameliorating the Harsh Result of the Statute of Limitations in Medical Malpractice Cases

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# THE CONTINUOUS TREATMENT RULE: AMELIORATING THE HARSH RESULT OF THE STATUTE OF LIMITATIONS IN MEDICAL MALPRACTICE CASES

## I. INTRODUCTION

Recently, South Carolina courts have been asked to adopt a rule that would effectively toll the statute of limitations in medical malpractice cases when a patient has remained under the care of her physician.[1] The principle is known as the "continuous treatment rule." The rule provides that when the doctor is engaged in a continuing course of treatment with the patient because of the nature of the patient's illness or injury, the statute of limitations does not commence until that treatment has ceased or been terminated.[2]

Many courts have adopted the continuous treatment rule as an exception to the traditional rule in which the limitations period begins on the date of the negligent act or omission. This judicial exception was first addressed by the Ohio Supreme Court in 1902.[3] In *Gillette v. Tucker*, the Ohio Supreme Court had to determine at what point the statute of limitations began to run—the date of the surgery or the date that the physician ceased treating the victim.[4] The *Gillette* court held that using the surgery date as the starting date for the statute of limitations would improperly burden the victim by forcing her either to sue the surgeon while her treatment continued or forego her cause of action.[5]

The importance of the continuous treatment rule increased after the medical malpractice insurance reform of the 1970s. At that time, decision-makers reacted to a perceived medical insurance crisis by enacting legislation aimed at curtailing a rise in medical malpractice insurance premiums for physicians and other health care providers.[6] Some of the studies indicated that

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1. *See* Preer v. Mims, 323 S.C. 516, 476 S.E.2d 472 (1996); Anderson v. Short, 323 S.C. 522, 476 S.E.2d 475 (1996); Dunbar v. Carlson, 341 S.C. 261, 533 S.E.2d 913 (Ct. App. 2000). For the purpose of this Comment, the application of the "continuous treatment rule" is limited to medical malpractice cases. However, South Carolina courts have contemplated the doctrine in other professional negligence claims. *See* Holy Loch Distribs., Inc. v. Hitchcock, 332 S.C. 247, 258, 503 S.E.2d 787, 793 (Ct. App. 1998) (declining to apply the continuous treatment rule to toll the statute of limitations for a legal malpractice claim).

2. 1 DAVID W. LOUISELL ET AL., MEDICAL MALPRACTICE ¶ 13.02[3], at 13-48 (2000); *see* 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 320 (1981 & Supp. 2000); 54 C.J.S. *Limitations of Actions* § 174 (1987 & Supp. 2000).

3. *See* Gillette v. Tucker, 65 N.E. 865 (Ohio 1902).

4. *Id.* at 869.

5. *Id.* at 871.

6. Robert W. George, Comment, *Prognosis Questionable: An Examination of the Constitutional Health of the Arkansas Medical Malpractice Statute of Repose*, 50 ARK. L. REV. 691, 697 n.31 (1998).

between 1960 and 1970, "insurance rates for surgeons rose 949.2 percent [and] rates for nonsurgical physicians increased 540.8 percent."[7] Legislators used a variety of methods to avert the crisis including limiting the amount of recovery, capping liability, and shortening the statute of limitations.[8]

At the time of the perceived crisis and in retrospect, commentators argued that the insurance panic "was grossly exaggerated."[9] Not only had the severity of the crisis been inflated, but the purported causes had been expanded beyond the presumed litigious sources.[10] Some argue that insurance companies raised premiums in an attempt to cover stock market losses.[11] Regardless of the initial causes of the increase in premiums, many state legislatures reacted to the perceived crisis and enacted tort reform schemes that placed "the brunt of such reform on those least able to bear its burdens—future medical malpractice victims."[12]

This Comment explores and discusses present jurisprudence regarding statutes of limitations, medical malpractice claims, and the "continuous treatment" rule and evaluates whether South Carolina should alter its uncertain position to provide more just results and a predictable guideline. Part II reviews the case law and statutory schemes of other jurisdictions that have addressed the continuous treatment rule, while Part III discusses the history behind South Carolina's position. Finally, Part IV addresses possible problems and complexities that South Carolina may face by adopting or declining the continuous treatment rule, including policy concerns and possible constitutional challenges.

## II. APPROACHES TO THE CONTINUOUS TREATMENT RULE

### *A. Adoption of the Continuous Treatment Rule*

Though *Dunbar v. Carlson*[13] did not take a position on the continuous treatment rule, the court recognized the equitable results of the continuous treatment rule. Many courts have been reluctant to create another express

7. Martin H. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 759 (1977).

8. *Id.* at 761.

9. Howard Alan Learner, Note, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143, 144 (1981).

10. *Id.* at 144-45.

11. *Id.* at 144.

12. *Id.* at 147. On the other hand, some jurisdictions have incorporated the continuous treatment rule into the applicable statute of limitations for medical malpractice claims. *See* Sheldon v. Sisters of Mercy Health Corp., 300 N.W.2d 746 (Mich. Ct. App. 1980).

13. 341 S.C. 261, 533 S.E.2d 913 (Ct. App. 2000).

exception to the statute of limitations.[14] However, a number of jurisdictions have explicitly addressed the doctrine.[15]

One of the first states to adopt the continuous treatment rule was New York, which adopted the rule in 1923.[16] Later, New York incorporated the continuous treatment rule into its applicable statute of limitations.[17] In *Borgia v. City of New York*, the Court of Appeals of New York explained that "at least when the course of treatment which includes the wrongful acts or omissions has run continuously and is related to the same original condition or complaint, the 'accrual' [of time] comes only at the end of the treatment."[18] The *Borgia* court justified its holding by stating the "'continuous treatment' [rule] is the fairer one" in part because a patient should not be made to "interrupt corrective efforts" of the caregiver.[19]

Even though the New York courts accepted the doctrine, the New York legislature expanded the doctrine in the 1970s by providing an exception to the statute of limitations based on equity.[20] Section 214-a of the Consolidated Laws of New York states that an action for medical malpractice must be commenced within thirty months "of the act, omission or failure complained of or last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the said act, omission or failure."[21]

Unlike New York, the move toward adoption of the continuous treatment rule in other jurisdictions has been neither quick nor easy. For example, in *Lane v. Lane*[22] the Arkansas Supreme Court finally accepted the continuous treatment rule in 1988.[23] The *Lane* decision was a shift from the previous position taken by the Arkansas court and considered "a major liberalization" of the Arkansas statute of limitations.[24] Before 1988, the Arkansas court interpreted the date of the accrual of the course of action to mean the time of the first injury giving rise to liability.[25]

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14. *See, e.g.*, Williams v. Edmondson, 520 S.W.2d 260, 267 (Ark. 1975) (holding that the General Assembly is the proper entity to decide the adoption of the continuing tort theory as it relates to public policy); *see also* discussion *infra* Part II.B.

15. *See* Farley v. Goode, 252 S.E.2d 594, 599 (Va. 1979) ("The approach we adopt in this case has been embraced by a number of other courts.").

16. *See* Borgia v. City of New York, 187 N.E.2d 777, 778-79 (N.Y. 1962).

17. *See* Dana David Peck, Comment, *The Continuous Treatment Doctrine: A Toll on the Statute of Limitations for Medical Malpractice in New York*, 49 ALB. L. REV. 64, 65 (1984).

18. *Borgia*, 187 N.E.2d at 778.

19. *Id.* at 779.

20. *See* Peck, *supra* note 17, at 87.

21. N.Y. C.P.L.R. § 214-a (McKinney 1990).

22. 752 S.W.2d 25 (Ark. 1988).

23. *See id.* at 28-29.

24. John D. Nichols, *Arkansas Adopts Continuous Treatment Rule to Toll Statute of Limitations in Medical Malpractice Actions*, 11 U. ARK. LITTLE ROCK L. REV. 405, 412 (1988-1989).

25. *See* Steele v. Gann, 123 S.W.2d 520 (Ark. 1939).

Arkansas courts historically deferred to the legislative intent behind the statute when declining to adopt the discovery rule or the continuing tort theory.[26] In *Lane* the Arkansas court reconciled the difference in the statutory language with the adoption of the continuous treatment rule by relying on the reasoning of the Virginia Supreme Court.[27] The *Lane* court recognized that Virginia adopted the continuous treatment rule and "adhered to the 'time of injury rule.'"[28] In *Farley v. Goode*[29] the Virginia Supreme Court held that a patient's claim for dental malpractice was not barred by the statute of limitations even though the tortious acts began outside the time limitations of the statute because the events surrounding the injury should be examined in their entirety since "'the whole transaction was inherently negligent.'"[30] Currently, the statute of limitations for medical malpractice claims in Arkansas is two years, and the statute provides that "the date of the accrual of the cause of action shall be the date of the wrongful act complained of and no other time."[31]

Connecticut has also adopted the continuous treatment rule.[32] Claims for medical malpractice in Connecticut are governed by Connecticut General Statute section 52-584.[33] Claims must be brought within two years of the injury, or discovery of the injury, but no more than three years from the date of the tortious event.[34] Even though the time limits in the Connecticut statute are more restrictive than the comparable South Carolina statute, Connecticut has adopted the continuous treatment rule.

In *Sherwood v. Danbury Hospital*[35] the Connecticut Supreme Court reaffirmed its approval of the continuous treatment rule.[36] In *Sherwood* the plaintiff received a blood transfusion during an operation performed by the defendant in April 1985.[37] The hospital had not tested the blood given for HIV antibodies, and after the transfusion, the remaining blood in the facility had been recalled to be tested.[38] The plaintiff was never informed of the possibility of postponing the surgery until the blood could be tested for the presence of

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26. *See Lane*, 752 S.W.2d at 27.
27. *See* Nichols, *supra* note 24, at 413.
28. *Lane*, 752 S.W.2d at 28.
29. 252 S.E.2d 594 (Va. 1979).
30. *Farley*, 252 S.E.2d at 599 (quoting Note, *Statute of Limitations—Cause of Action for Malpractice Accrues at Termination of Treatment under Doctrine of "Continuous Treatment,"* 31 FORD. L. REV. 842, 843 (1963)).
31. ARK. CODE ANN. § 16-114-203(a)-(b) (Michie 1987 & Supp. 1999).
32. *See* Giambozi v. Peters, 16 A.2d 833, 835 (Conn. 1940), *overruled by* Foran v. Carangelo, 216 A.2d 638, 640 (Conn. 1966) (overruling the allowance of "death and its direct consequences" as recoverable damages when not specified by statute).
33. CONN. GEN. STAT. ANN. § 52-584 (West 1991 & Supp. 2000).
34. *See id.*
35. 746 A.2d 730 (Conn. 2000).
36. *Id.* at 736.
37. *Id.* at 733.
38. *Id.*

HIV nor of the possibility of contracting HIV from contaminated blood, even after the hospital became aware of the possibility.[39] In March 1995 the plaintiff first learned she was infected with the HIV virus as a result of her 1985 transfusion.[40] In *Sherwood* the court held the continuous treatment doctrine could be applied to toll the statute of repose within section 52-584 if the plaintiff could establish a continuing duty on the part of the physician.[41]

### *B. Rejection of the Continuous Treatment Rule*

Some states reject the continuous treatment rule.[42] Kansas, for example, has expressly rejected the doctrine.[43] In *Becker v. Floersch*[44] the Kansas Supreme Court rejected the plaintiff's argument, which was that ignoring the continued status of care under a physician would result in the court permitting "'doctors and surgeons to escape the consequences of their negligent acts by simple expedient of the statute of limitations.'"[45] The court declined to "intrude on the prerogatives of the legislature."[46] Since *Becker*, the Kansas courts have routinely rejected the continuous treatment rule.[47]

In *Hill v. Hays*[48] the Supreme Court of Kansas, affirming its rejection of the continuous treatment doctrine, held "[l]imitations are created by statute and are legislative, not judicial acts."[49] In addition, the *Hays* court held that "the enumeration by the legislature of specific exceptions to a statute of limitations excludes all others by implication."[50] Not only did the *Hays* court defer to the

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39. *Id.*

40. *Id.* at 733.

41. *Sherwood*, 746 A.2d at 736.

42. *See* 1 LOUISELL ET AL., *supra* note 2, ¶ 13.02[3], at 13-50 n.54 (listing jurisdictions declining adoption of the rule).

43. *See* Becker v. Floersch, 110 P.2d 752, 754 (Kan. 1941).

44. 110 P.2d 752 (Kan. 1941).

45. *Id.* at 754.

46. *Id.* This case sounds in tragic comedy. The defendant doctor promised the plaintiff a cure for abdominal pain within ten treatments, and in the end, the patient endured over ninety treatments and lost the ability to bear children as a result of the doctor's treatments. *Id.* at 752-54.

47. *See* P.W.P. v. L.S., 969 P.2d 896, 903-04 (Kan. 1998) (outlining the history of the Kansas rejection of the continuous treatment doctrine to the present time).

48. 395 P.2d 298 (Kan. 1964).

49. *Id.* at 301; *cf.* Schanilec v. Grand Forks Clinic, Ltd., 599 N.W.2d 253, 255 (N.D. 1999) (holding when a statute does not express the time when an action accrues, the determination is for the court).

50. *Hays*, 395 P.2d at 301. Oddly enough, though, the Kansas court refused to adopt the continuous treatment doctrine within the context of a medical malpractice action, the court applied the continuous representation rule to toll the statue of limitations until the end of an attorney-client relationship in legal malpractice actions. Bonin v. Vannaman, 929 P.2d 754, 774 (Kan. 1996).

legislature, but its interpretation of legislative acts also leaves little room for any judicially created exceptions.[51]

Illinois is another jurisdiction that has declined to adopt the continuous treatment rule. In *Cunningham v. Huffman*[52] the Supreme Court of Illinois expressly held that "[they] cannot adopt the continuous course of treatment doctrine as formulated by the appellate court."[53] The appellate court had applied the continuous course of treatment rule to toll the statute of repose for the plaintiff's medical malpractice claims.[54] Though the issue was the continuous treatment rule as applied to a statute of repose, the position of Illinois is apparent as applied to the statute of limitations as well: "Had the General Assembly intended the continuous course of treatment doctrine to be the law of this State, it could have specifically provided so."[55]

Though the *Cunningham* court explicitly rejected the continuous course of treatment rule, it did construe the statute of repose to allow the plaintiff to pursue her cause of action.[56] *Cunningham* allows a plaintiff to circumvent the statute of repose when there is "an ongoing course of continuous *negligent* medical treatment."[57]

### *C. Confusion*

Although New York and Connecticut have clearly adopted the continuous treatment rule and Kansas has decidedly rejected it, many states have not yet clearly defined this area.[58] Therefore, adoption of the continuous treatment rule in many jurisdictions remains an open question. For example, Maryland maintains that it has not changed its position regarding the continuous treatment rule, yet its courts have reached the same result under reasoning similar to if the continuous treatment rule had been adopted.[59] In *Hill v. Fitzgerald* the Maryland Court of Appeals determined that the continuous treatment rule did not apply.[60] The *Hill* court held under Maryland Code section 5-109(a)[61] that the time of injury for commencement of the statute is the time of the negligent

51. *See* Hecht v. First Nat'l Bank & Trust Co., 490 P.2d 649, 656-57 (Kan. 1971) (holding the continuous treatment doctrine is generally "a judicial effort to soften the harshness of the statutory accrual rule existing in a particular jurisdiction").

52. 609 N.E.2d 321, 324 (Ill. 1993).

53. *Id.* The appellate court held "that in medical malpractice actions, the statute of repose is triggered only on the last day of treatment, and if the treatment is for the same condition, there is no requirement that the negligence be continuous throughout the treatment." *Id.*

54. *Id.*

55. *Id.*

56. *See id.*

57. *Id.* at 325.

58. *See, e.g.*, Froysland v. Altenburg, 439 N.W.2d 797, 801 (N.D. 1989) (hinting at the possibility of adoption but not at that time).

59. *See* Hill v. Fitzgerald, 501 A.2d 27, 32 (Md. 1985).

60. *Id.* at 31-32.

61. MD. CODE ANN., CTS. & JUD. PROC. § 5-109(a) (1998).

act "coupled with some harm."[62] Under this approach, the statute may commence to run before treatment ceases, and the continuous treatment rule appears inapplicable.[63]

However, in *Jones v. Speed*[64] the Maryland Court of Appeals approved a result similar to the adoption of the continuous treatment rule.[65] In *Jones* the plaintiff asserted that each visit was "a separate medical injury."[66] Though the court stated the "continuous course of treatment rule remains lifeless in Maryland,"[67] the court went on to hold that the plaintiff could prove that the physician committed separate acts of negligence during the course of treatment.[68] Similarly, in addition to allowing each visit to be considered a potential claim, the *Jones* court may have extended the definition of injury "to include the progression or worsening of a single condition."[69] Though the Maryland court did not acknowledge the potential ramifications of its holding, the *Jones* case was a move toward a more favorable rule for medical malpractice victims.

Another example of unclear precedent is Delaware.[70] Delaware stresses its disapproval of the continuous treatment rule, but its case law suggests confusion on the issue.[71] In Delaware, malpractice claims fall into one of two statutory time limitations—two years from the date of injury or three years for an "inherently unknowable" injury.[72] In *Ewing v. Beck* the Supreme Court of Delaware affirmed the lower court's holding that "since the continuing treatment doctrine had not been enacted by the Delaware legislature or adopted by this Court, the continuing treatment doctrine was not applicable and the . . . claims were time barred."[73] In examining the continuous treatment rule, the Delaware court engaged in a lengthy analysis of legislative intent and requirements for alleging a claim based on a continuous course of negligent treatment.[74]

Ultimately, the Delaware court held that an action does exist for continuous negligent medical treatment.[75] The court held that the claimant must allege such a continuum of treatment "with particularity," but upon doing so, "the statute of limitations runs for two years from the date of the last act in the negligent

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62. *Hill*, 501 A.2d at 30.
63. *See id.* at 32.
64. Jones v. Speed, 577 A.2d 64 (Md. 1990).
65. *Id.* at 70.
66. *Id.* at 65.
67. *Id.* at 68.
68. *Id.* at 70.
69. Judith C. Ensor, Jones v. Speed*: Redefining Medical Injury in Medical Malpractice Claims?*, 2 MD. J. CONTEMP. LEGAL ISSUES 1, 11 (1991).
70. *See* Ewing v. Beck, 520 A.2d 653 (Del. 1987).
71. *See id.* at 656.
72. *Id.* at 659.
73. *Id.* at 656.
74. *See id.* at 659-61.
75. *Id.* at 664.

continuum" prior to discovery.[76] In essence, the Delaware court adopted the continuous treatment rule subject to the discovery rule but placed a high standard of proof on the plaintiff to establish the existence of a continuous treatment.[77]

## III. SOUTH CAROLINA BACKGROUND

### *A. Statutory Framework for Medical Malpractice Actions in South Carolina*

Before 1988 the statute of limitations for medical malpractice actions was six years.[78] In 1988 the General Assembly amended the statute to its current version:

> [A]ny action . . . to recover damages for injury to the person arising out of any medical, surgical, or dental treatment, omission, or operation . . . must be commenced within three years from the date of the treatment, omission, or operation giving rise to the cause of action or three years from [the] date of discovery or when it reasonably ought to have been discovered, not to exceed six years from [the] date of occurrence, or as tolled by this section.[79]

Thus, the present statute of limitations in South Carolina for medical malpractice claims is three years from the date of the injury or from the date of discovery, with a maximum of six years from the date of the injury.[80]

### *B. South Carolina Precedent*

In 1996 the South Carolina Supreme Court decided a pair of cases, *Preer v. Mims* and *Anderson v. Short*, both of which concerned the shortened statute of limitations and may have been decided differently under the former statute.[81] In *Preer* the patient sued his doctor claiming that because of the doctor's

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76. *Ewing*, 520 A.2d at 664-65.

77. *Id.* at 665.

78. S.C. CODE ANN. § 15-3-545(A) (Law Co-op. Supp. 1978).

79. S.C. CODE ANN. § 15-3-545(A) (Law Co-op. Supp. 1999). The six-year limitation in § 15-3-545 is the repose period which places an outer limit on commencing actions. *See supra* note 69.

80. 1977 S.C. Acts 182. South Carolina does not publish legislative history, so determining the reason for the General Assembly's change in the existing statute is an onerous task if such history is achievable at all. When the General Assembly amended the time limitation for medical malpractice cases, other actions such as contract claims were also shortened from six to three years. S.C. CODE ANN. §§ 15-3-530-535 (Law. Co-op. 1976 & Supp. 1999).

81. Preer v. Mims, 323 S.C. 516, 476 S.E.2d 472 (1996); Anderson v. Short, 323 S.C. 522, 476 S.E.2d 475 (1996).

negligence, he was addicted to a pain-relieving drug,[82] and the patient's wife sued for loss of consortium.[83] The doctor began seeing Preer in 1982 and continued to prescribe the drug at Preer's request until 1991.[84] The action was commenced on April 29, 1993.[85] The doctor moved for and was granted a directed verdict on the ground that the action was barred by the statute of limitations.[86] Preer alleged that the continuous treatment rule tolled the statute of limitations and thereby made the action timely.[87]

The *Preer* court held that a decision on the continuous treatment rule was unnecessary because even if it adopted the rule, Preer's claim would be limited by the discovery rule.[88] In South Carolina, the discovery rule causes the statute to start when "facts and circumstances of the injury would put a person of common knowledge and experience on notice that some right of hers has been invaded or that some claim against a party might exist."[89] As Preer should have discovered the injury more than three years prior to the filling of the claim, the claim was untimely.[90]

Like *Preer*, *Anderson v. Short*[91] involved a patient and spouse who filed claims for medical malpractice and loss of consortium, respectively. The patient began seeing the doctor in 1983, and her treatment continued until March 1991.[92] In her claim filed on January 13, 1994, she alleged that she became addicted to a prescription drug due to the doctor's negligence in prescribing the drug.[93] The action was filed within three years from the last treatment by the doctor and, therefore, would not have been barred if the statute of limitations was tolled until the cessation of the treatment.

However, the *Anderson* court affirmed the trial judge's dismissal of the action because Anderson conceded that she had discovered the addiction more than three years prior to the filing of the action.[94] In dicta, the *Anderson* court clarified its proposed position regarding the continuous treatment rule: "If the continuous treatment rule with the above-discussed discovery exception were

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82. *Preer*, 323 S.C. at 517-18, 476 S.E.2d at 472-73.

83. *Id.* at 518, 476 S.E.2d at 473.

84. *Id.* at 517, 476 S.E.2d at 472. During this time, Preer was also receiving prescriptions for the drug from other doctors. *Id.*

85. *Id.* at 518, 476 S.E.2d at 473.

86. *Id.*

87. *Id.*

88. *Preer*, 323 S.C. at 520, 476 S.E.2d at 474. *But cf.* Otto v. Nat'l Inst. of Health, 815 F.2d 985, 988 (4th Cir. 1987) (noting that under federal law, the discovery of "both the existence and the cause of [the] injury" starts the running of the statute of limitations).

89. Arant v. Kressler, 327 S.C. 225, 229, 489 S.E.2d 206, 208 (1997).

90. *Preer*, 323 S.C. at 520, 476 S.E.2d at 474. The *Preer* court reversed the directed verdict for the loss of consortium claim because under § 15-75-20 a claim for loss of consortium is not derivative. *Id.* at 521, 476 S.E.2d at 474.

91. 323 S.C. 522, 524, 476 S.E.2d 475, 476 (1996).

92. *Id.* at 523, 476 S.E.2d at 476.

93. *Id.* at 524, 476 S.E.2d at 476.

94. *Id.* at 525, 476 S.E.2d at 477. The dismissal of the loss of consortium action was affirmed because the husband failed to properly appeal the rulings unlike the wife in *Preer*. *Id.*

the law in South Carolina, it would not be used to toll the accrual of a medical malpractice action for patients who discovered their injury giving rise to a cause of action during treatment."[95]

Although the South Carolina Supreme Court did not adopt the continuous treatment rule in either case, the Court of Appeals reached a different conclusion in *Dunbar v. Carlson*,[96] a case similar to *Preer* and *Anderson*. In *Dunbar* the court upheld a claim for medical malpractice based on a continuous relationship between a patient and her dentist without adopting the continuous treatment rule.[97] The patient, Dunbar, started seeing her dentist, Carlson, in 1983 and continued to see him until June 24, 1994.[98] On September 26, 1995, Dunbar filed an action alleging that Carlson negligently failed to diagnose or treat Dunbar for periodontal disease.[99] During the trial, Dunbar's daughter stated that she had become concerned about Carlson's treatment of her mother as early as 1992.[100] After this testimony, Carlson moved to amend his answer to include defenses based on the statute of repose and the statute of limitations.[101] Defense counsel asserted that "South Carolina does not recognize the continuous treatment rule."[102] On the other hand, the plaintiff argued that there were negligent acts or omissions that did occur during the statutory period even if the initial negligence began at an earlier time.[103]

The Court of Appeals affirmed the lower court's denial of the defendant's request to amend his answer to include a statute of repose defense because under the facts of this case, the denial was not an abuse of discretion by the trial judge.[104] In addition, the court reversed the lower court's grant of the defendant's request to amend his answer to include a statute of limitations defense because it was "improvidently granted."[105] By denying the defendant's request to amend his answer to include affirmative defenses, the *Dunbar* court moved toward the equitable result that the continuous treatment rule would have provided by recognizing that the doctor's initial failure did not terminate his duty to act with due care during the subsequent visits with the patient.

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95. *Id.*

96. 341 S.C. 261, 533 S.E.2d 913 (Ct. App. 2000).

97. *Id.* at 270-71, 533 S.E.2d at 918. Similarly, Georgia based rulings on reasons other than the continuous treatment rule to uphold claims. Vitner v. Miller, 430 S.E.2d 671, 672 (Ga. App. 1993). However, Chief Judge Pope's concurrence strongly urged the court to adopt the continuous treatment rule. *Id.* at 673. Georgia subsequently adopted the continuous treatment rule. Williams v. Young, No. A00A1393, 2000 WL 1770056, at *5 (Ga. Ct. App. Dec. 1, 2000).

98. *Dunbar*, 341 S.C. at 264, 533 S.E.2d at 914.

99. *Id.* at 264, 533 S.E.2d at 915.

100. *Id.* at 265, 533 S.E.2d at 915.

101. *Id.*

102. *Id.* at 270, 533 S.E.2d at 918.

103. *Id.*

104. *Dunbar*, 341 S.C. at 271, 533 S.E.2d at 917.

105. *Id.* at 268.

## IV. ANALYSIS

### *A. Arguments for Strict Interpretations of Statutes of Limitations*

The states which have allowed the use of the continuous treatment rule or a de facto version of the rule have often done so based on notions of fairness or "corrective justice."[106] Those jurisdictions where the doctrine has been rejected have based their decisions on legislative intent and the protective purpose of the statute of limitations.[107]

Statutes of limitations are a source of protection both for potential defendants and for the efficiency of the judicial system, and there are strong arguments for limiting liability through strict interpretations of the statutes of limitations.[108] One traditional view is that "[s]tatutes of limitation are an integral part of our judicial system and are grounded in policy considerations including affording defendants the chance to defend themselves, protecting defendants from the prolonged fear of litigation, and preventing stale claims."[109] In addition, the nature of the health care industry offers another reason for limiting the ability of potential victims to sue—malpractice

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106. *See* F. PATRICK HUBBARD & ROBERT L. FELIX, THE SOUTH CAROLINA LAW OF TORTS 4-6 (2d ed. 1997) (stating that compensation of victims is not a goal of the tort system, but is a means of accomplishing a goal like deterrence or corrective justice); *see also* Learner, *supra* note 9, at 166 (stating that compensation of victims by the wrongdoer was the basis for common-law tort remedies, but the modern focus is on deterrence).

107. As stated earlier, courts have rejected the doctrine out of deference to the legislature where the court found that it was for the legislature to change the statute to incorporate an exception. *See supra* text accompanying notes 46-51.

108. *See* Nichols, *supra* note 24, at 408; *see also* McEntire v. Malloy, 707 S.W.2d 773, 776 (Ark. 1986) (noting that the statutes of limitations ensure prompt filing of claims and protect defendants from an evidentiary process tainted by time). Another mechanism for protecting potential defendants is a statute of repose. Section 15-3-545 of South Carolina's Code contains both a limitation of actions period and a repose period. S.C. CODE ANN. § 15-3-545 (Law Co-op. Supp. 1999). A statute of repose differs from a statute of limitations in that the statute of repose dictates an absolute time period in which a claim must be brought, and the exceptions applicable to statutes of limitations are not extended to statutes of repose. "A statute of repose generally begins to run at an earlier date and runs for a longer period of time than the otherwise applicable statute of limitations unaffected by the discovery accrual rule." W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30 at 168 (5th ed. 1984) [hereinafter PROSSER AND KEETON ON TORTS] (footnote omitted). The South Carolina Supreme Court has held that the tolling provisions applicable to the statute of limitations in medical malpractice claims do not toll the statute of repose for those actions. Langley v. Pierce, 313 S.C. 401, 405, 438 S.E.2d 242, 244 (1993); *see also* HUBBARD & FELIX, *supra* note 106, at 32 n.32 (stating the statute of limitations and statute of repose are distinguished based on the type of right conveyed by each statute); *cf.* George, *supra* note 6, at 693 (stating the statute of limitations and statute of repose are distinguished on the basis of the date of commencement for accrual of an action).

109. Robert C. Jarosh, Note, *Torts/Wrongful Death—Should a Wrongful Death Action Expire Before the Decedent Does? A Wrong Turn for Wrongful Death.* Edwards v. Fogarty, *962 P.2d 879 (Wyo. 1998)*, 35 LAND & WATER L. REV. 235, 251-52 (2000).

insurance costs.[110] Lastly, statutes of limitations provide a service to the judicial system by ensuring that potential plaintiffs act promptly in asserting potential claims and helping to keep the proverbial floodgates of litigation under control.[111]

### *B. Arguments for Liberal Interpretations of Statutes of Limitations and for Adoption of the Continuous Treatment Rule*

Though statutes of limitations protect potential defendants and promote the efficiency of judicial system, courts are sensitive to other concerns. Within the tort system, fairness is a powerful idea hinging on the notion that wrongdoers should "'correct' their wrong by restoring the victim to his prior status."[112] Although fairness must also be extended to potential wrongdoers, the reluctance to prejudice a possible defendant must be weighed against the position of the potential victim.[113] Strict interpretations of statutes of limitations may lead to unfair prejudice and the denial of rights to a medical malpractice victim.[114] As a result of "apparent injustice," many courts have adopted "various devices to circumvent" such strict rules.[115] The continuous treatment rule is a device to achieve such an end.

In addition to the fairness considerations and deference to the legislative intent of limiting exposure of medical professionals, deterrence is another policy consideration that impacts the tort system and judicial determinations.[116] The theory is premised on the idea that by making a potential tortfeasor liable for her actions, that person will be deterred from engaging in tortious

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110. *See* Christopher J. Trombetta, Note, *The Unconstitutionality of Medical Malpractice Statutes of Repose: Judicial Conscience Versus Legislative Will*, 34 VILL. L. REV. 397, 427 n.166 (1989). The argument that medical malpractice insurance costs are unfair to physicians must be kept in context. The amount paid for insurance may be a large sum, but the amount paid constitutes a small portion of a health care provider's gross income. In 1986, malpractice insurance was approximately 3.7% of a physician's gross income, 0.7% lower than in 1976 and 1979. *Id.*

111. *See* HUBBARD & FELIX, *supra* note 106, at 22-23 (discussing the effect of statutes of limitations in helping to ease the burdens on the courts).

112. *Id.* at 6.

113. *Id.* at 14-15.

114. *See* Trombetta, *supra* note 110, at 403 (noting the "manifest unfairness that early medical malpractice statutes of limitations produced").

115. PROSSER AND KEETON ON TORTS, *supra* note 108, at 166; *see also* Crosby v. Glasscock Trucking Co., 340 S.C. 626, 641, 532 S.E.2d 856, 863 (2000) (Toal, J., dissenting) (arguing for imposition of liability for a fetal wrongful death as consistent with "recent decisions follow[ing] a trend of abolishing well-established tort doctrines which inhibit the proper apportioning of liability based on fault"); Nichols, *supra* note 24, at 406 (stating the increased frequency of court intervention to prevent injustice to medical malpractice victims).

116. *See* HUBBARD & FELIX, *supra* note 106, at 6-10. Professors Hubbard and Felix list other policy considerations which are not discussed in this Comment, but these considerations may also be relevant to the future of the continuous treatment rule. *Id.*

conduct.[117] Also, imposing liability on wrongdoers promotes other aspects of the tort system—efficiency of the system[118] and spreading of loss.[119]

The continuous treatment rule fosters deterrence in at least two different ways. First, under the present law in South Carolina, a negligent health care provider might not be liable if her negligent acts began more than three years before the action.[120] Under the continuous treatment rule, a physician who continues to engage in negligent conduct does not escape liability merely because the first negligent act occurred more than three years ago. This aspect of the rule also plays into the fairness considerations to potential victims.

Second, the continuous treatment rule allows a physician to cure any negligent act or omission before imposing liability.[121] The physician can "correct the injury and avoid potential malpractice actions."[122] In this respect, fairness also promotes giving a physician the chance to undo a wrong or encouraging a physician to attempt to undo wrongs whether known to the physician or not. This is not to say that a physician will necessarily be cognizant of a wrong, but the rule accepts the reality that physicians make mistakes. Even in a highly skilled profession, there will be mistakes.[123] This scenario is distinctly different from claims against physicians for fraudulent concealment.[124] The physician is in the best position to make such corrections and should be allowed to do so.[125] In the alternative, the physician's "[f]ailure to repair the original damage provides the rationale for tolling the statute."[126]

A third benefit of the continuous treatment rule is that it serves a purpose unique to the relationship between physician and patient by fostering that

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117. *See* HUBBARD & FELIX, *supra* note 106, at 6; *see also* Simmons v. Tuomey Reg'l Med. Ctr., 341 S.C. 32, 49, 533 S.E.2d 312, 321 (2000) (holding that an "aspect of tort law" is "the desire to give parties with crucial duties a keen incentive to do everything possible to avoid violating those duties"); Brown v. Anderson County Hosp. Ass'n, 268 S.C. 479, 487, 234 S.E.2d 873, 877 (1977) (holding that "[i]mmunity fosters neglect and irresponsibility, while liability encourages the exercise of due care").

118. *See* HUBBARD & FELIX, *supra* note 106, at 6-10 (outlining "efficient accident prevention" which in its simplest form makes accident costs to the wrongdoer greater than the costs of preventing the accident).

119. *See Brown*, 268 S.C. at 486, 234 S.E.2d at 876 (holding there is a "'legislative and judicial policy in distributing losses'" (quoting President and Directors of Georgetown College v. Hughes, 130 F.2d 810 (D.C. Cir. 1942)).

120. *See* S.C. CODE ANN. § 15-3-545(A) (Law Co-op. Supp. 1999).

121. *See* 1 LOUISELL ET AL., *supra* note 2, ¶ 13.02[3], at 13-52.

122. Nichols, *supra* note 24, at 408.

123. *See* Oliver v. Kaiser Cmty. Health Found., 449 N.E.2d 438, 440 (Ohio 1983) (discussing the "'ordinary and usual mistakes incident to even skilled surgery'" (quoting Bowers v. Santee, 124 N.E. 238 (Ohio 1919))).

124. *See* 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 322 (1981 & Supp. 2000) (discussing the general rule that statutes of limitations are tolled until a patient discovers a negligent act that the physician fraudulently concealed).

125. *See* 1 LOUISELL ET AL., *supra* note 2, ¶ 13.02[3], at 13-52.

126. Horton v. Carolina Medicorp, Inc., 472 S.E.2d 778, 782 (N.C. 1996); *see* cases cited *supra* note 117.

relationship.[127] A patient may continue to see a doctor and receive treatment without losing her recourse if that treatment is negligently performed.[128] Unfortunately, there seems to be a rise in the type of illnesses and injuries that require long term care, such as cancer, and any interruption in that course of treatment would be harmful to that patient. It is illogical and inefficient to expect a patient to cease treatment to pursue a potential claim or to pursue a claim while continuing treatment or to expect a patient to be able to ascertain that the physician may be the cause of the harm.[129] In addition, patients are not necessarily trained as medical experts and lack the knowledge to question or even understand a physician's chosen course of treatment. A patient should have the right to place confidence in her physician without having to worry about a forfeiture of remedy if that confidence was ill-placed.

The continuous treatment rule, as an exception to the statute of limitations, furthers not only the physician-patient relationship, but it also comports with tort law policies that justify placing liability on a wrongdoer once it has been determined that there has been a wrong.[130] Adoption of the continuous treatment rule furthers the goals of tort law more efficiently than strict interpretations of statutes of limitations by helping to place the victim in the same position that she could have been in but for the negligence of the physician by making the physician liable (corrective justice), by deterring negligence, and by averring the need to correct a wrong.

### *C. Implementation Obstacles*

In addition to weighing the policy considerations by balancing the interests of potential defendants, potential victims, and judicial economy, further concerns should be considered. If the South Carolina Supreme Court were to adopt the continuous treatment rule, there would be difficulties in defining the application and scope of the rule to give clear guidance to practitioners. The court must clearly articulate the requirements that must be met to invoke the rule to ensure an optimal result.[131] The court may refine the requirements by expressly determining what constitutes "continuity" and "termination" of treatment and determining how the discovery rule is to be applied.[132]

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127. *See* Nichols, *supra* note 24, at 408.

128. *See id.*

129. *See* Langner v. Simpson, 533 N.W.2d 511, 519-20 (Iowa 1995).

130. *See* HUBBARD & FELIX, *supra* note 106, at 17-18 & 18 n.64 (emphasizing the primary step of ascertaining a legally recognizable wrong before determining liability).

131. *See* Nichols, *supra* note 24, at 415 (illustrating the confusion when courts do not clearly define the parameters of the rule).

132. *See, e.g.*, J.R. Zepkin, *Virginia's Continuing Negligent Treatment Rule:* Farley v. Goode *and* Fenton v. Danaceau, 15 U. RICH. L. REV. 231, 239-44 (1981) (discussing unanswered questions left by the Virginia Supreme Court after adopting the continuous treatment rule); *see also* 1 LOUISELL ET AL., *supra* note 2, ¶ 13.02[3], at 13-46-13-59 (stating courts distinguish between cessation of treatment and cessation of the physician-patient relationship.); Nichols, *supra* note 24, at 415 (stating that after Arkansas adopted continuous treatment rule question of

*1. Continuous*

As the South Carolina Supreme Court sets out to define the parameters of the continuous treatment rule, it must be aware of the problems that have arisen in other jurisdictions. First, courts have had problems defining continuous.[133] Defining continuous may result in effectuating the protective purpose of statutes of limitations or allowing legitimate claims to be brought against defendants whose conduct needs to be scrutinized because the particular facts of each case will dictate whether the treatment was continuous.[134] In defining the continuity of the treatment, the court may choose to concentrate on the nature of the illness and the relationship between the physician and patient, or the court may focus on the actual time elements surrounding the treatment.[135] Some courts have held that when the length of time between visits or treatments is longer than the applicable statute of limitations, then the treatment was not continuous.[136] In some jurisdictions, the issue of whether the treatment was continuous is a question for the jury.[137] Yet, in other jurisdictions, the courts have been extremely liberal in applying the continuous treatment rule by allowing recovery when a negligent act is followed by subsequent visits that were not negligent.[138] Courts that focus on the nature of the relationship between the physician and patient may concentrate on whether the physician owed a continued duty of care to the patient after the negligent act.[139] Though the approaches vary significantly, focusing on the treatment and the actions taken in conjunction with the treatment seems to be the most predictable and fair approach. One significant advantage of the continuous treatment rule is that it allows a patient to continue a course of treatment without interruption or interrogation of the physician.[140] In addition, the opportunity for the physician to correct any wrongs in the course of treatment is eliminated when the treatment ceases. Also, because a physician-patient relationship may span a

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"whether statute will be tolled if there is only a single negligent act, rather than a series of negligent acts" was left unanswered).

133. *See* Peck, *supra* note 17, at 73-76 (acknowledging the difficulties associated with defining continuous).

134. *See id.* at 76.

135. *See id.* at 73-76.

136. *See* Collins v. Sullivan, 679 N.E.2d 423, 425 (Ill. App. Ct. 1997) (holding that nine years between visits did not constitute continuous treatment even when visits were prompted by same illness or condition).

137. *See* Jones v. Neuroscience Assocs., Inc., 827 P.2d 51, 59 (Kan. 1992) (holding the plaintiff must be afforded the right to establish the existence of a continuous treatment by a trier of fact).

138. *See* O'Laughlin v. Salamanca Hosp. Dist. Auth., 319 N.Y.S.2d 128, 130-31 (1971); Borgia v. City of N.Y., 187 N.E.2d 777, 779 (N.Y. 1962).

139. *See* Sherwood v. Danbury Hosp., 746 A.2d 730, 736 (Conn. 2000) (stating the duty must have continued after the negligent act).

140. *See Borgia*, 187 N.E.2d at 779 (noting the absurdity in expecting a patient to interrupt treatment).

person's life, it would be illogical to hold a physician liable for a misdiagnosis made when the adult patient was a child.[141]

### 2. *Date of Accrual*

A court must decide at which point the continuous treatment rule ceases to toll the statute of limitations. The two obvious options are the last date of the "continuous" treatment or the termination of the physician-patient relationship.[142] The better approach seems to be the one taken by the *Borgia* court which held that it is the continuous "treatment for the same or related illnesses or injuries, continuing after the alleged acts of malpractice, not mere continuity of a general physician-patient relationship."[143]

### 3. *Interacting with the Discovery Rule*

Another issue to be addressed if the continuous treatment rule is adopted is how it should interact with the discovery rule. The discovery rule is another tool which the courts use to toll statutes of limitations.[144] The discovery rule and the continuous treatment rule could be used coextensively or merged together. As already implied by the South Carolina Supreme Court in *Anderson v. Short*, the discovery rule would apply even if the continuous treatment rule were adopted.[145] This position is in accord with many of the other jurisdictions adopting the continuous treatment rule.[146] However, the discovery rule has inherent problems that the continuous treatment rule purports to assuage because it is precisely the nature of the physician-patient relationship as an impediment to a patient's ability to detect negligence on the part of her physician which makes the continuous treatment rule appealing.[147] In addition, due to the continuous nature of particular treatments, the date of the tortious conduct or injury may not be ascertainable at all.[148] Another concern is the

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141. *See id.* (acknowledging the possibility of a patient bringing a lawsuit years after an illness but avoiding such a pitfall because the treatment must be for the same illness not "any kind of illness").

142. *See* Zepkin, *supra* note 132, at 240-42 (discussing the question of the date of accrual left unanswered by the Virginia courts).

143. *Borgia*, 187 N.E.2d at 779; *see also* 1 LOUISELL ET AL., *supra* note 2, ¶ 13.02 (citing to jurisdictions that set accrual at the termination of the treatment).

144. *See* PROSSER AND KEETON ON TORTS, *supra* note 108, at 165-67 (noting the "infectious" spread of the discovery rule).

145. *See* Anderson v. Short, 323 S.C. 522, 525, 476 S.E.2d 475, 477 (1996).

146. *See* Nichols, *supra* note 24, at 408-09 (asserting most jurisdictions adopting the continuous treatment rule apply it to toll the statute of limitations until discovery).

147. *See* Collins v. Wilson, 984 P.2d 960, 963 (Utah 1999).

148. *See* Cheryl A. Fisher, Comment, *Is There Light at the End of the Tunnel? Putting a Stop to the Controversy of Which Statute of Limitations to Use in a Medical Malpractice Action in Texas:* Bala v. Maxwell, *909 S.W.2d 889 (Tex. 1995)*, 22 T. MARSHALL L. REV. 346, 356 (1997).

potential and probable lack of medical knowledge on the part of the patient which would impair the patient's ability to second guess the physician's actions.[149] The injury could be the culmination of many acts, some negligent and some not. In summary, the discovery rule does not adequately address the unique complexities surrounding the physician-patient relationship.[150] The patient may see the physician as a source of hope during a long battle with cancer. This situation cannot be measured by a reasonable person standard because it is almost impossible to understand what one would do to survive until one is in that situation.

### 4. *Possible Constitutional Challenges*

Another source of controversy arises from potential constitutional challenges to statutes of limitations at both the state and federal levels. Most of the challenges predicated on a violation of the Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution have failed due to the level of scrutiny that the United States Supreme Court applies to such challenges.[151]

While it appears that courts and legislatures would be insulated from any federal constitutional challenge for declining to adopt the continuous treatment rule, it may be that the failure to adopt the rule could be considered unconstitutional at the state level.[152] State challenges to the constitutionality of limitations on a patient's right to a remedy have been more successful than federal challenges.[153] State challenges are broadened to utilize guarantees in state constitutions beyond those inherent in the United States Constitution.[154] These additional guarantees include equal protection, due process, open courts, and right-to-a-remedy provisions in the various state constitutions.[155] The argument is that it is unconstitutional to "discriminate against only a few

149. *See* Peck, *supra* note 17, at 69-71.

150. There is another complexity left unaddressed in this Comment—the role of health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs and PPOs may also play a role in encouraging adoption of the continuous treatment rule because they may impair a patient's ability to seek effective treatment. Even if a patient were to suspect a physician's actions, the patient may not be permitted under her healthcare plan to seek a second opinion or to change physicians. *See generally* Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 287-88, 294-95, 311, 325 (1995) (outlining the roles of HMOs and PPOs as well as the expanding theories of liability, in particular those predicated on limiting a patient's freedom of choice and denial of proposed medical treatment); William A. Chittenden, III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 476-85 (1991) (discussing potential liability stemming from the cost-containment systems employed by HMOs and PPOs).

151. *See* Trombetta, *supra* note 110, at 407-09.

152. *See id.* at 407.

153. *See id.* at 409.

154. *See id.* at 409-11.

155. *See id.*

malpractice plaintiffs."[156] The argument is bolstered by the fact that such a limitation on such a small number of potential plaintiffs and damage awards "could not possibly have any meaningful impact on the medical malpractice insurance industry."[157] The challenges at the state level offer little guidance, though some have been successful.

There seems to be little prospect of a challenge to the constitutionality of a statute of limitations under the South Carolina Constitution in light of the present disposition of the South Carolina Supreme Court regarding statutes of repose. The South Carolina Supreme Court has already upheld the constitutionality of the statute of repose for medical malpractice claims in *Smith v. Smith*[158] under an equal protection challenge. Deferring to the General Assembly, the court looked for "'any reasonable hypothesis'" to support the legislature's actions.[159] The test that the court employed is as follows: "[t]he requirements of equal protection are satisfied if 1) the classification bears a reasonable relation to the legislative purpose sought to be effected; 2) the members of the class are treated alike under similar circumstances and conditions; and 3) the classification rests on some reasonable basis."[160] Under the reasonable basis scrutiny, the *Smith* court found a reasonable relationship between the statute and the legislative intent to protect health care providers.[161]

## V. CONCLUSION

Simply put, "it is unfair to bar a legitimate claim because of the patient's trust in the physician or the latent nature of the injury."[162] South Carolina courts will eventually address cases requiring a definitive position on the continuous treatment rule.[163] In the past, the South Carolina Supreme Court has been able to dispense justice without adopting the rule, deciding the few relevant cases on other grounds.[164] Although many jurisdictions have declined to accept the rule based on deference to the legislature, the courts often face issues before they have been brought to the attention of the legislature. Though it would be better for the General Assembly to amend the statute of limitations to include a tolling provision for continuous treatment, a case may soon arise which calls

156. 1 LOUISELL ET AL., *supra* note 2, ¶ 13.02[2][b], at 13-40 (noting Washington has already held that the statute of repose was unconstitutional).

157. *Id.* at 13-41.

158. 291 S.C. 420, 424-25, 354 S.E.2d 36, 39 (1987).

159. *Id.* at 424, 354 S.E.2d at 39 (quoting Gary Concrete Prods., Inc. v. Riley, 285 S.C. 498, 331 S.E.2d 335 (1985)).

160. *Id.* (quoting Gary Concrete Prods., Inc. v. Riley, 285 S.C. 498, 331 S.E.2d 335 (1985)).

161. *Id.* at 424-25, 354 S.E.2d at 39.

162. Nichols, *supra* note 24, at 408.

163. *See* Horton v. Carolina Medicorp, Inc., 472 S.E.2d 778, 781 (N.C. 1996) (holding that the continuous treatment rule is to be the law in that jurisdiction).

164. *See* Preer v. Mims, 323 S.C. 516, 520, 476 S.E.2d 472, 474 (1996); Anderson v. Short, 323 S.C. 522, 525-26, 476 S.E.2d 475, 477 (1996).

for an immediate application to avoid dismissing the only recourse that a victim may have.[165] Further, the legislature may not be forced to address the issue soon because potential victims are unidentifiable, and thus, no lobby of individuals who might someday be the victim of medical malpractice during a continuous course of treatment exists.

The ramifications of the continuous treatment rule, if adopted, could spread to many other areas in which a professional relationship exists.[166] In fact, the District of Columbia applied the continuous treatment rule to medical malpractice *after* it adopted the rule for legal malpractice claims.[167] Thus, the adoption of the continuous treatment rule may have wide-spread effects.

The justifications for adopting a rule that would allow the victims of lengthy medical negligence the opportunity to seek a remedy exceed the justifications for strict adherence to prior interpretations of the statute of limitations, such as the need to protect the medical profession from an insurance crisis. The benefit to the limited number of potential claimants could be immeasurable while imposing a minimal burden on potential defendants and their insurance companies. Not only should fairness dictate the adoption of the continuous treatment rule, but the rule itself can be framed in a manner that will insure it is not abused by potential claimants that could have filed their claims but waited needlessly. The court itself has the tools necessary to prevent claimants' abuse of the continuous treatment rule while insuring that malpractice victims with valid claims would have a recourse that they may not presently have.

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165. *See* Brown v. Anderson County Hosp. Ass'n, 268 S.C. 479, 486, 234 S.E.2d 873, 876 (1977) (stating courts should not legislate, but should they need to do so, then it "'should be wise and safe'" (quoting Lindler v. Columbia Hosp., 98 S.C. 25, 39, 81 S.E. 512, 517 (1914))).

166. *See* Nichols, *supra* note 24, at 414 (stating that the continuous treatment rule has been extended to lawyers, accountants, insurance brokers, and architects).

167. *See* Anderson v. George, 717 A.2d 876, 878 (D.C. 1998).

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